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ATTITUDES TOWARD THE MENTALLY ILL: RESEARCH PERSPECTIVES

REPORT OF AN NIMH WORKSHOP JANUARY 24-25,1980

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ATTITUDES TOWARD THE MENTALLY ILL: RESEARCH PERSPECTIVES

REPORT OF AN NIMH WORKSHOP JANUARY 24–25,1980

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THE WHITE HOUSE

WASHINGTON

January 23, 1980

Dear Friends,

I am pleased that the National Institute of Mental Health has convened this workshop in response to the recommendations of the President's Commission on Mental Health. As you know, public attitudes about mental illness have long been of great concern to me. Too often the mentally ill person must live a marginal existence when discharged from a mental hospital. Too often the mentally ill return to their communities to face ignorance, prejudice and fear. Discrimination and social obstracism are common. Many are unable to find employment to provide for their basic needs.

We already know that each of us as individuals can foster greater public understanding. But, we need more accurate information concerning the best way to reduce the stigma toward the mentally ill. New solutions to the very complex issues involved in stigma must be found.

It is my hope that through these two days of greater discussion and sharing of information, you will identify new opportunities through research to help overcome this stigma which is so harmful not only to the mentally ill, but to all humankind.

With best wishes,

Sincerely,

Rosalynn Carter

New Directions for Research on Stigma
Towards the Mentally Ill
National Institute of Mental Health
Parklawn Building
Rockville, Maryland

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FOREWORD

The mentally ill have always had to cope with discrimination stemming from negative perceptions of mental illness. This discrimination has a pervasive influence on the lives of the mentally ill. Its effects are evident in problems of physical, psychological, and financial accessibility of mental health services, in the frequent mismatch between services and needs, and in the difficulties faced by mental patients in finding jobs and places to live. Although the effects of discrimination are readily apparent, understanding the sources and finding solutions can present a complex challenge.

In January 1980, the National Institute of Mental Health sponsored a research workshop on attitudes toward the mentally ill in an effort to identify the questions most central to eliminating discrimination and promoting a better life for the mentally ill in the community. The workshop was inspired, in part, by a recommendation of the President's Commission on Mental Health that more research is needed in the area of public understanding and behavior toward the mentally ill. The need for public understanding has become particularly critical since deinstitutionalization has become a major alternative for many chronic mental patients.

The solution to the problems faced by the mentally ill in the community rests on public understanding and support. To obtain such support, certain intermediate steps must be taken. First, the message to the public must be based on accurate information, such as whether the dangerousness of ex-patients can be predicted accurately. Second, the sources of negative perceptions of the mentally ill must be identified, with the respective roles of media portrayals, actual contact with the mentally ill, and other sources clarified.

The search for the most efficient way to eliminate discrimination and integrate ex-patients into the community must be based on a solid research foundation. Past research efforts concerning negative reactions to the mentally ill have often been

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directed toward negative attitudes. However, as the workshop participants have brought out, the *attitudes* of the public are important only insofar as they predict the *behavior* of the public. Finding the most effective way to change that behavior is the ultimate goal.

The NIMH-sponsored workshop reported here has identified research needs and priorities in the hope of stimulating new research that will facilitate the integration of the mentally ill into the mainstream of society. It serves to remind us of the dual tasks ahead: to refine still further our understanding of how and why the mentally ill acquire the burden of prejudice, and, based on that understanding, to devise effective ways to lighten the load.

Herbert Pardes, M.D.
Director
National Institute of Mental Health

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Overview

Lenore Gelb

Prejudice and discrimination toward people who appear deviant are facts of life. People who are identified as "mentally ill" are faced with a special set of concerns. They are "ill" in a way that many people do not understand and also fear. With so much unsureness about the causes, consequences, and cures of an array of disorders with many forms, it is no wonder that negative stereotyped views toward mental illness are common.

In an effort to understand the forces that underly such negative attitudes and behavior and to stimulate new research, the National Institute of Mental Health (NIMH) sponsored a 2-day workshop, January 24 and 25, 1980. Mrs. Carter's interest in "stigma" and mental illness was one catalyst for this conference. The need to address recommendations from the President's Commission on Mental Health relating to stigma was also a stimulus. Main goals of the multidisciplinary workshop included assessing how much researchers currently know about stigma and mental illness and identifying new areas for research.

The workshop participants, who included psychologists, sociologists, psychiatrists, communications experts, geographers, a former patient, and others, explored the often elusive, multifaceted research areas related to attitudes toward mental illness. In the course of the workshop, four types of general issues became apparent. The first issue was fundamental to all the topics discussed by the participants: clarifying the concepts and terms needed to provide groundwork for future research. The second general issue was most in line with the stated purpose of the workshop: discussing research findings and questions

related to public attitudes toward the mentally ill. A third issue was more practical: pinpointing methods for changing public attitudes and facilitating the integration of ex-patients in the community. A last issue permeated every discussion: identifying the methodological problems inherent in trying to measure and analyze public attitudes and behavior.

BASIC ISSUES

One fundamental conceptual issue is the need for appropriate operational definitions of terms used in research so that findings can be pooled and integrated. For example, an operational definition of the term "mental illness" is needed. Many people with different types of behavior and different diagnoses can be considered as mentally ill, yet attitudes toward mental illness do not reflect fully this diversity in the patient population. Any definition of mental illness should include specific descriptors, such as epidemiologic, diagnostic, or demographic characteristics, in order to differentiate among the different types of people who are labeled as "mentally ill."

Along the same lines, the workshop participants also agreed that precise definitions of words used to define attitudes are also needed. In planning this workshop, the term "stigma" was used to describe negative attitudes toward mental illness. The dictionary definition of stigma calls it a "mark or brand of disgrace." Yet, it soon became apparent in the conference discussion that the term was too strong to describe the full range of negative reactions toward the mentally ill. Although some patients may experience stigmatization, the term is not generalizable to all patients' experiences. Moreover, using such an emotionally charged, strongly negative word to describe attitudes toward mental illness and the mentally ill does not encourage objective thinking about the problem. Thus, one important consensus of the workshop on stigma was not to use the word except with great care and in very specific situations.

Another preliminary step in understanding attitudes and behavior toward the mentally ill is to specify *whose* attitude is under study. The person experiencing mental illness has one reality—the professional treating that person has another. Members of the general public have yet another perception, often based on very little direct contact with the severely mentally ill. Families with a mentally ill member, law enforcement

officials, third-party payers and the Government all have very different relationships to the mentally ill that shape their perceptions and influence their behavior.

SUBSTANTIVE ISSUES—PUBLIC ATTITUDES

Negative attitudes toward the mentally ill stem from both rational and irrational sources. Thus, as emphasized by the workshop participants, any research on negative attitudes should identify these sources. For example, one perception of the mentally ill is that they are dangerous and unpredictable. What is the origin of this perception? One controversy surrounding the source of negative perceptions involves labeling. Does merely labeling a person "mentally ill" increase the public's fear of dangerousness? Does the labeling process affect a person's self-concept and behavior so that others find him or her strange? Is there actually a kernel of truth to the public's fear of the mentally ill? Is the labeling or the behavior itself the important influence on negative public attitudes? Although the answers to these questions are elusive, they must be found if we are to understand why the mentally ill are sometimes feared and excluded from the mainstream of society.

The workshop participants identified many of the factors that affect self-perceptions and public perceptions of mental patients. For example, the media, especially TV, might increase fear of the mentally ill by portraying them as dangerous criminals. The providers, as part of the treatment system, may do potential damage simply by diagnosing a person mentally ill. The treatment system can have various effects depending on where the person is treated. For example, treatment at a State hospital might have more serious implications for both the public and the patient than being treated at a private hospital in the community.

A family can be a positive influence on a mentally ill member's self-perception by offering emotional and practical support. However, the family can deny that there is a problem and delay help-seeking, thus prolonging mental distress and perhaps ultimately contributing to long-term hospitalization. The health care financing system can also influence how the mentally ill are perceived and treated. Third-party payers encourage labeling by insisting on a reimbursable diagnosis. They may be reluctant to reimburse patients for mental health care,

acting as though mental illness were less serious than other health problems. Further, fear of loss of privacy and confidentiality resulting from use of the third-party-payment system can also discourage seeking mental health care, particularly if a bout with mental illness might be recorded in an employment history.

The civil and criminal justice system can also affect people's attitudes toward mental illness. The use of legal terminology can create negative and inaccurate images of the mentally ill. Terms such as "insane" and "incompetent to stand trial" can foster negative images when applied to the mentally ill. Legal procedures such as "guardianship" can lead the patient as well as the family and the court to a belief in dependency and helplessness which does not encourage autonomy and recovery.

PRACTICAL ISSUES—PUBLIC EDUCATION

Issues involved in the reintegration of ex-patients in the community present another challenge to researchers. Anticipating some negative reaction to ex-patients, it often is necessary to assess what a particular community's reaction will be and, if necessary, attempt to change negative attitudes. Communities vary widely in ways that affect their relationship to the mentally ill person. For example, a community's collective political values—whether traditional, liberal, or conservative—may affect attitudes toward a neighborhood mental health facility. The socioeconomic level of the community may also contribute, as may past experience with a mental health facility or with patients. Knowing which communities might be likely to reject or welcome a sheltered facility can help social planners and policymakers direct their efforts for change.

Choosing an effective public education approach should involve collaboration between public education researchers and attitude researchers. Whether one believes that attitudes cause behavior or that behavior causes attitudes will influence the public education strategy one chooses. Changing employers' attitudes toward hiring ex-patients might be a first goal in a public education campaign.

METHODOLOGICAL PROBLEMS—MEASURING ATTITUDES

Methodological difficulties involved in measuring attitudes compound the problems encountered in analyzing differing per-

ceptions of mental illness. To date, studies have described observable characteristics of patients and communities using fairly objective criteria. But attitudes of the mentally ill toward themselves and others, as well as attitudes of the community toward patients and mental health facilities in their midst, are not as accessible. Further, techniques to measure attitudes are sometimes methodologically weak and not always used uniformly across research studies. Therefore, it is difficult to replicate findings. To complicate matters even further, the relationship between attitudes and behavior can often be tenuous. For example, a person might express a realistic and tolerant attitude toward mental illness and yet oppose having a mental health facility established close to home. Further intervening factors often may influence a person's actions so that the answers to an attitude survey may predict very little about the respondent's actual behavior.

In the final analysis, the goal is to eliminate or at least reduce discriminatory behavior toward the mentally ill. We cannot assume that changing negative attitudes necessarily will end discriminatory behavior. However, better understanding and knowledge of both negative attitudes and behaviors toward the mentally ill is vital. Determining the research questions and directions that might lead to this understanding is a first step toward eliminating some of the obstacles the mentally ill face in the community.

One Personal Experience: Before and After Mental Illness

Joan Houghton

Part of the recovery process from mental illness involves overcoming a problem of even greater magnitude than the illness itself: the negative feelings and attitudes of others toward the mentally ill. For lack of a better word, we call this problem "stigma." For me, the stigma of mental illness was as devastating as the experience of hospitalization itself.

In this paper I tell of my experiences as a recovered patient —as a private person and in my roles as a mental health professional, a community volunteer, and as a graduate student. My experiences are presented here in three ways: the distillation of facts; the contrasting lifestyle before and after mental illness; and recommendations for change and research.

Prior to being hospitalized for mental illness, I lived an enviable existence. Rewards, awards, and invitations filled my scrapbook. My diary tells of many occasions worth remembering.

The months and years since my hospitalization have been spent adjusting to the experience. At first there was the state of existence: without feelings, without a desire to live, without hope. I remember struggling to get out of bed every day, hating my own mirror image, plotting my own death, praying for a miracle to change me, to return me to a happy time and place.

There were no more parties to attend. In their place were quiet, private lunches with a few close friends who endured my obsession with death. Gone were laughter and fun. Instead were frequent escapes to my bed in hopes of prolonged sleep, death.

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The crisis of mental illness appeared as a nuclear explosion in my life. All that I had known and enjoyed previously was suddenly transformed, like some strange reverse process of nature, from a butterfly's beauty into a pupa's cocoon. There was a binding, confining quality to my life, in part chosen, in part imposed. Repeated rejections, the awkwardness of others around me, and my own discomfort and self-consciousness propelled me into solitary confinement.

My recovery from mental illness and its aftermath involved a struggle—against my own body, which seemed to be without energy and stamina, and against a society that seemed reluctant to embrace me. It seemed that my greatest needs—to be wanted, needed, valued—were the very needs which others could not fulfill. At times, it felt as though I were trying to swim against a tidal wave.

It was almost 2 years after my hospitalization before I became motivated to challenge the unfair, harsh treatment of my world—a world that was denying me readmission to graduate school; that was closing doors to volunteer work with community mental health programs; that was preaching sermons about the devils who live in mental institutions; and that was threatening my career with disability retirement. With the support and encouragement of my family and friends, I decided to challenge those who were denying me access to places and opportunities that I enjoyed before my illness.

My first challenge began when I attempted to enroll for classes to complete my graduate studies in psychology. I was advised in writing that, because of my extended break, I would have to reapply for admission. I never dreamed that I would receive a form letter stating: "A careful evaluation of your application and supporting credentials has now been completed. On the basis of these documents, it has been determined that you do not currently meet our standards of admission."

When I asked what standards I had not met, there were no answers. When I asked, "Why?" there was silence. I drew energy from my own anger. I began to mobilize my resources to engage in a battle with the system.

My NIMH affiliation gave me many advantages: I had knowledge of resources and the support of many who knew my capabilities and potential. I prepared a well-organized brief with chronology of events and supporting papers and presented

my case to the Mental Health Law Project (MHLP). They agreed to help me.

The lawyer worked with me behind the scenes, as the director of an intense drama. Letters were drafted by me, reviewed by him, and sent over my signature. I went to meetings alone, as my own representative. Every phone call, every meeting, was documented with details about the date, time, attendees, topics discussed, and future action. We were in touch by phone to plan strategies and approaches.

After months and months of written communications, I was invited to meet with the Department of Psychology chairperson to discuss my plans for completing of my graduate work. When I arrived for the meeting I was greeted by three university officials. I was told that I was not wanted on campus. When I asked, "Why?" the room fell silent.

I documented the events of the meeting, which seemed like a legal hearing, to the chairperson. Finally, a letter came saying that I had been accepted for admission. However, the conditions for acceptance were incredible: I had to finish my coursework in a very short period of time (an impossible time frame since I was working full time), and I had to present a plan of study—a requirement designed specifically for me.

Although I felt a sense of defeat, the Mental Health Law Project rallied. My lawyer sent to the university president a letter that detailed my attempts to gain readmission and further stated that, in the lawyer's opinion, I had been discriminated against by the university on the basis of my mental illness.

Within 1 month I received a letter of acceptance, the extension, and blessings of the university. Last year, my adviser presented my diploma to me at a special ceremony in my honor. I had graduated with high honors and a membership in the psychology honor society.

Three other experiences after my recovery also illustrate how others can react negatively toward the mentally ill. With hopes that others might benefit from my experiences, I wrote to the hospital where I had been confined and asked about doing volunteer work. The reply from the director said that their volunteer staff did not include former patients.

Only partially discouraged, I approached a local mental health organization. They invited me to speak before a group of

patients in a work rehabilitation program. The director of the organization was interested and enthusiastic. However, when she presented the idea to the board of directors, I was rejected. They had not met me, they did not know me, but they judged my involvement as inappropriate. Privately, the director told me that she thought the members were "threatened" by my participation.

The third experience occurred in a place of considerable importance to me: church. One Sunday I went to church alone after being absent for several weeks. The minister (who knew of my history, faith, and strong belief in God) began his sermon with reference to the devil. He said, "If you ever want to be convinced of the existence of the devil, you should visit a mental institution." To illustrate his point, he described people who had lost control of their bodily functions, who screamed out obscenities. I left church after the sermon, drove home vowing never to return to that church as long as that minister preached from the pulpit. At home, however, I began to replace my anger with doubt. Maybe I misunderstood.

At my invitation the minister visited our home to discuss his philosophy about mental illness and the mentally ill. His visit was our last encounter. Not only did he see evil in mental illness but he conveyed an unforgiving attitude to those who have the misfortune of residing in mental hospitals.

I discuss the last experience reluctantly because it occurred at NIMH. Given the sensitivities associated with the incident, I will limit my discussion to a summary of the facts.

Prior to my illness, a promotion action had been submitted for processing. After my hospitalization, it was withdrawn with the bureaucractic explanation that it was impossible to justify a promotion for someone who was on an extended leave of absence. The silent message conveyed with the withdrawal action was demoralizing: "You are dysfunctional, unworthy of a higher level of work. You must prove your worth all over again." It appeared as a sentence rather than as a decision.

Some months later in an office struggle between labor and management, several employees received threatening and intimidating remarks from management. In my case, I was offered the option of retiring—at the age of 35—on disability!

With a fighting spirit, I filed a grievance against management. The case was settled in my favor, after a long and

painful struggle, again with the assistance of the Mental Health Law Project. The result was a most satisfactory assignment, training, and career opportunity.

The four experiences suggest that negative attitudes toward the mentally ill appear in virtually every place in our society. They also explain, from my point of view, why so many acute cases become chronic. By comparison, a mental hospital provides a positive, supportive environment.

My life has been changed not only by the experience of mental illness but by the negative attitudes I have encountered since my illness. Although in the past 2 years I have achieved goals which seemed beyond my reach soon after my illness, I am now the antithesis of the assertive, vivacious, gregarious person I was before my illness. Excitement and spontaneity have been replaced by reclusiveness and thoughtful planning. Writing and reading now substitute for singing and dancing. Solitary walks with my dog have taken the place of neighborhood volleyball games. I enter social situations with reservation and apprehension. I suffer great pain from a condition I call "professional paralysis."

From my perspective, negative attitudes toward the former patient reflect a variety of interrelated factors. They involve one person's behavior, another person's attitude toward that behavior, cultural influences, protective instincts, an uninformed public, and many other variables. For example, mental hospitals have been portrayed as "snake pits." They have a mysterious, frightening quality about them. Most people would not dare venture inside an "insane asylum" for fear of death, injury, or contamination.

We have an innate instinct to protect ourselves from danger. By nature, therefore, we avoid those who are unpredictable by behavior, or by group identity. We are taught as children to avoid those who are different, and, unquestionably, the behavior of mental patients is different. In addition, religion sometimes teaches us that mental illness is a satanic influence.

The warehousing environment of most mental hospitals does little to prepare released patients for the real world. All too often we are released from hospitals with our heads on straight and everything else out of joint. Drugs force us back into reality long before we're ready to deal with it. The world looks and

feels real again, but we're not. We closet ourselves. Some of us never come out.

It concerns me that negative attitudes toward the mentally ill are often perpetuated in both subtle and blatant ways by mental health professionals themselves. It was the department of psychology of a university which denied me readmission to graduate school and a mental health professional who threatened me with disability retirement.

In addition, in the process of treating patients, mental health professionals often fail to treat people. We, as mental health professionals, speak of "bold new approaches," of "innovative treatment modalities," and of "plans for change," and yet nothing really changes. If we really want and need better mental health services, we must move off the platform of self-serving rhetoric, examine the present system, and begin to rearrange the parts to fit the world as it exists today and might be tomorrow.

As a mental health professional who has experienced mental illness, commitment to a State mental hospital, and the negative attitudes of others, I offer these comments and recommendations:

1. We need to think about integrative health care—treating *all* ill people in nonlabeling environments. Those who enter "mental health" facilities are branded "sick" in a unique way—a way that sets them apart from all others who are in need of health treatment. Do you think the news of my illness would have traveled as fast if I had been admitted to a general hospital rather than a mental institution? Would I have had more than three visitors during my 5-week stay? We need to learn how to help the former patient make environmental changes that contribute to healthier living. Are group homes and halfway houses labeling environments?
2. Individualized plans of treatment need to be developed for patients. It has been documented that behavior modification is an effective therapeutic technique, but has anyone really addressed the dehumanizing effects of its use? Have we become so obsessed with making behavior appear "normal" and "acceptable" that we ignore what causes abnormality? Are people who act "normal" because of chemotherapy really ready to return to society, to work, to be

with their families? Or do we set up what appears to be a support system for them, push the eject button, and return to the ward to treat those who are not yet ready for release?

3. We need to develop natural as well as artificial support systems. Are we perpetuating the stigma problem by enrolling former patients in support groups with others who are so labeled? When I was a patient, I recall being loaded onto a bus with other patients and unloaded in Alexandria, Virginia, to shop with about $2 in my pocket. We were sent in pairs with explicit instructions to return to the bus within an hour. The discomfort attached to being publicly identified as a patient from the funny farm—in a place I had previously toured with my friends—became a driving force to return to the bus. My greatest need upon release from the hospital was to be with "normal" people, to be accepted in places where I had been before. I resisted and resented group identity formations as a former patient. From my perspective, we must be careful not to create chronic mental illness by building support systems that reinforce the problem. We should think about training patients in good health care, aimed at preventing future illness, and in interpersonal skills so that they can rebuild supportive relationships with others. Alternative forms of treatment—such as holistic health care—should be researched and evaluated to determine whether they can be applied effectively to avoid hospitalization.
4. The economic impact of mental illness on patients and on the family must be addressed. It took me years to repay my sick leave. My promotion potential has been thwarted by my illness, recovery, and struggles against the system. Is there a relationship between the economic impact of mental illness and the changes in lifestyle which typically follow?
5. Since work is the primary source of ego strength for most of us, we need to examine the former patient's world of work and need to assess working environments for their mental health safety. Meaningful work must be offered in settings that are caring and patient. Supervisors should be trained to administer tasks which build esteem and confidence and do not set a person up for failure. We should

provide meaningful roles in our society for former patients as caregivers, consultants, and researchers.

Determinants of Public Attitudes About Mental Illness: Summary of the Research Literature

Judith G. Rabkin

The attitudes of others toward mental illness influence the experiences of those who bear the label. Historically, and even at present, the status of mental patients often leads to diminished respect and friendliness on the part of other people. Such behavior exacerbates whatever social difficulties derive from the disorder itself.

Although the adverse effects of public attitudes on the careers of individual mental patients provide sufficient reason to measure and define such attitudes systematically, additional considerations further justify their examination. Public attitudes affect decisions about funding allocations for publicly supported mental health services and, furthermore, are believed to influence the willingness of people to formulate their problems within a mental health framework and to seek appropriate help. As such, community attitudes may act as filters, regulating the timing and flow of mental health referrals.

Until about 25 years ago, the vast majority of severely disturbed people were sent to distant mental hospitals for years, if not forever—essentially out of sight and mind. More recently, with the advent of new treatment methods, new psychiatric perspectives, and revised professional and legislative policies, there are growing numbers of both acutely and chronically disturbed people in the community. Their increasing presence may engender friction with their neighbors and, indeed, has already done so in several cities across the country. Community

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objections to the establishment of local psychiatric treatment and residential facilities are fairly common, and it has been estimated (Piasecki 1975) that for every facility that has been opened another was prevented from doing so by local opposition. Neglecting such situations as well as the force of public attitudes may exacerbate public fears and encourage a retreat to custodial care and removal from the community, at least for those mental patients dependent on public treatment and support.

In view of the large numbers of Americans who have spent time in mental hospitals, the problem of attitudes toward the mentally ill can be regarded as a significant public health issue. In 1955, there were 599,000 mental patients hospitalized at any one time. Since this peak, the hospitalized population has declined, primarily due to shorter stays. Further, admissions have also begun to drop since the early 1970s. Nonetheless, the hospitalized population is still significantly large—171,000 in 1976.

Mental patients are not randomly distributed throughout the population but are concentrated within specific groups and geographical areas. Moreover, mental patients do not constitute a homogeneous group. Some are acutely disturbed individuals who have recently entered the mental health system, while others are chronically disabled older people who may have spent years in institutions and who are now returning to the community because of policy changes inaugurated by hospital administrators and politicians. These two groups differ not only in age, sex ratio, duration of illness, symptomatology, and prognosis, but also in terms of their needs for community services, supports, and rehabilitative efforts.

During the past 30 years, over 150 studies have examined attitudes about mental illness. While some have sought to evaluate attitudinal changes before and after training of various health groups, the majority have tried to describe general attitudes held by the public about mental illness and the mentally ill. A brief historical review of these descriptive studies is followed by a summary of findings regarding characteristics of patients and respondents associated with attitudinal variations. Most of the studies in this field that were published before 1976 have been summarized and cited in an earlier review (Rabkin

1976), so that references in this presentation are largely restricted to studies appearing in the past 5 years.

HISTORICAL TRENDS IN PUBLIC ATTITUDES TOWARD MENTAL ILLNESS

The stigma of the label of mental illness has been widely documented since the early 1950s. Several major comparative studies published before 1960, based on a variety of populations (rural, urban; middle-class, working-class; white, black; southern, midwestern; students, adults) together established that the mentally ill were characteristically regarded with fear and dislike. People tended to overlook behavior that professionals regarded as pathological, evidently as a mechanism of denial or the product of ignorance rather than because of greater tolerance of deviance. When the label was assigned authoritatively, the person so labeled was stigmatized and avoided. People were generally outspoken about the discomfort and anxiety evoked by the subject of mental illness and the presence of a person so labeled.

Since 1960, students of public attitudes toward mental illness generally have had two quite different orientations. The first consists of investigators who feel optimistic about the public's greater capacity to label mental illness as such and see it as an illness like any other. Members of this group tend to regard mental illness in the traditional psychiatric framework of a medical model. Mental illness is regarded as a constellation of diseases with specific symptoms, courses, and outcomes—many of which can be cured by appropriate treatment. The second group, with more of a sociological orientation, includes workers who tend to be pessimistic about the nature of public attitudes. They personally do not subscribe to the medical model of illness, do not see it as an improvement when more of the public does so, and regard labeling itself as harmful. Allowing for the possibility of genetic predispositions, mental illness is seen as an exaggerated pattern of behavior common to all, precipitated by stressful transactions between the person and his or her social environment.

Crocetti and his associates (1974) are perhaps the leading proponents of the "optimistic viewpoint." They reject the proposition that the mentally ill are stereotyped, stigmatized, or rejected and believe that talking about stigma may actually

generate it (Herbert 1978). Based on their findings from community surveys, they conclude that in the 1970s a larger proportion of the public can identify mental illness as such, that more people acknowledge personal acquaintance with mental patients, that less social distance is demanded, that there is greater optimism about the chance for cure, and greater acceptance of the medical model of mental illness.

Quite a few other studies have led to more pessimistic conclusions, although it is probably the *magnitude* of the changes that Crocetti and colleagues cite rather than the *direction* that is controversial. While no one claims that stigma has increased in recent years, many are not impressed with the size of its decrease, either, and feel that appreciable resistance to the mentally ill is still observable. One example is the work of Tringo (1970), who established a hierarchy of disability groups based on their relative social acceptability. Of 21 different categories of disability, the least preferred were the mentally ill. Somewhat more desirable were the ex-convict, the mentally retarded, and the alcoholic. Conclusions based on this work and other recent studies (Colbert et al. 1973; Farina and Felner 1973; Neff and Husaini 1979; Olmstead and Durham 1976) cast some doubt on the utility of encouraging the public to adopt a medical model of illness or learn to identify and label mental illness as such.

Brockman, D'Arcy, and Edmonds (1979), in a careful critique of 22 studies assessing public attitudes toward the mentally ill, noted a series of methodological problems characterizing virtually all of them. They concluded that while not all of the studies were so flawed as to be meaningless, those with negative findings "are somewhat less suspect overall than the positive ones." Their own restudy (D'Arcy and Brockman 1977), of a sample originally interviewed in 1952 by Cumming and Cumming (1957) in an early landmark study, found no noteworthy change in attitudes toward the mentally ill 23 years later.

At present, it is not clear whether the stigma associated with mental illness, the sense of disgrace, or the reality of rejection is experienced by nearly everyone, recovered or not, known to have a history of mental illness, or only by those who remain manifestly symptomatic or impaired. Several studies comparing public reactions to the label of mental illness and to disturbed behavior itself cumulatively suggest that it is the behavior, not

the label, that evokes the negative response. Relatively well-adjusted, well-educated people who develop a psychiatric disorder but recover and return to good functioning are unlikely to suffer extensively from stigma because of their history of illness (Kirk 1974; Lehmann et al. 1976; Schwartz et al. 1974; Segal 1978). On the other hand, patients with chronic or progressive disorders, who never acquired occupational and social competencies, or who do not return to their formerly adequate levels of adjustment continue to be perceived as mental patients with all the negative connotations that the label carries. It is the more-or-less permanently disabled people, who are visibly different and less competent, and require intermittent or long-term support from nonfamily sources to maintain themselves in the community, who tend to be the objects of fear, stigma, aversion, and avoidance.

In contrast to this set of findings, others report that even recovered ex-patients are treated worse than other people because of the stigma of mental illness. As reported by the President's Commission on Mental Health Task Panel on Public Attitudes and Use of Media for Promotion of Mental Health, "Testimony came to the Commission from men and women who could not find employment even after recovery" (1978). Elsewhere in their report they noted, "Stigma attaches to individuals while they are suffering from a mental illness but haunts their lives" afterwards as well (1978). In the Panel's view, "There is still shame and guilty secrecy associated with mental illness and . . . public attitudes remain an obstacle to 'combating mental illness'" (1978).

It seems that the more visible the manifestations of disorder, the greater the probability of experiencing stigma. It is also likely that mediating factors such as social class, social resources, levels of educational and occupational achievement, and lifestyle influence risk of stigmatization. Rabkin agrees with Lamb's conclusion (1979), "We cannot yet dismiss the phenomenon of 'closed ranks,'" public resistance to those regarded for whatever reasons as mentally ill. However, more research is needed to ascertain the range of people likely to experience the burden of stigma.

The present status of public attitudes toward the mentally ill can be summarized by these points:

1. People know more about mental illness than they did 20 years ago but still considerably less than many health professionals think is desirable.
2. The message "mental illness is an illness like any other" has been widely disseminated and is widely accepted by the lay public. However, some health professionals would prefer to disseminate other messages.
3. Overt stigma has diminished but seems to have reached a plateau in its descent.
4. Manifestly disturbed behavior elicits more stigmatization than does the mental illness label alone. Recent evidence suggests that many psychiatrically recovered former patients make social recoveries as well, while the chronically disabled continue to be avoided and excluded.
5. Even now, mental patients who continue to be identified as such by their behavior or history are not treated like ex-medical patients when it comes to housing, school admission, jobs, or general good will. Many people continue to be frightened by the notion of major mental illness and believe that others are also frightened, although it is becoming less socially acceptable to say so.
6. There is some risk that the current level of public acceptance will decline because of the presence of increasing numbers of chronically disabled mental patients who are returned to or maintained in the community, supported by Government resources. While the friction thus engendered is frequently attributed to lack of social and psychiatric services to meet the needs of these patients, there is reason to doubt the sincerity of this argument in view of the strong opposition by many communities to the establishment of local psychiatric facilities in their midst.

CHARACTERISTICS OF PATIENTS THAT INFLUENCE ATTITUDES TOWARD THEM

Once investigators established the general nature of public attitudes toward mental illness, they began to consider what aspects of mental illness and what qualities of mental patients influenced these attitudes. It gradually became evident that the major troublesome dimensions associated in the public mind with the stereotype of the mental patient are those of unpredictability, dangerousness, and lack of accountability. Long ago,

Nunnally (1961) suggested that unpredictability is the cornerstone of public attitudes toward mental patients. Unpredictable behavior, seen as frightening and disruptive, typically invites rejection and avoidance. In addition, many people believe that mental patients are more likely than others to be dangerous, despite professional reassurances to the contrary. This fear is probably central to most peoples' concerns about dealing with mental patients. In a recent California community survey (Hazleton et al. 1975), only 17 percent of respondents agreed that "mental patients are not dangerous." The scientific evidence published up to now has shown a dramatic change in arrest data: Studies published before 1960 found lower rates, and recent studies, decisively higher rates of arrests among discharged mental patients compared to members of the general public.

As Steadman and others have observed, these findings are highly related to the increasingly disproportionate numbers of patients with criminal records predating their psychiatric hospitalization. For example, in New York State, 40 percent of all male patients admitted in 1975 had prior criminal records (Steadman, Cocozza, and Melick 1978). Changes in admission and discharge policies also play a role in the altered composition of mental patient populations in public facilities. Dangerous behavior is now virtually a prerequisite for involuntary admission in many States, while hospital stays are now measured in weeks instead of years, providing greater opportunities for criminal recidivism. Consequently, it is not surprising that discharged mental patients as a group have higher arrest rates than do members of the general public. These replicated findings deserve wider acknowledgement than they have received from members of the mental health professions, many of whom continue to dismiss public fears of dangerousness of mental patients as unfounded or biased.

Beyond these concerns about unpredictability and dangerousness, public concerns are complicated by the fact that many people, especially if they endorse a medical model of illness, feel that mental patients should not be held morally or legally accountable for their disturbed behavior (Schwartz and Schwartz 1977). The use and widespread publicity associated with the legal defense of "not guilty by reason of insanity" reinforces this view. Thus deprived of both legal and moral

sanctions, people tend to resort to avoidance in response to disturbed or disturbing behavior.

In addition to the general characteristics pervasively associated with the label and stereotype of mental illness, particular personal and psychiatric attributes also influence public attitudes.

Personal characteristics of patients influence the attitudes of others toward them. As one might expect, patients are less readily rejected by people of similar sociodemographic backgrounds than by those who perceive them as different. Perhaps that is why a patient's social status, income level, ethnic group, and degree of community involvement influence peoples' attitudes. The lower the social status, the more likely, rejection. The same is true for low-status minority-group membership, lack of social ties, and lack of social graces. In addition, males are more likely to be stigmatized than females, perhaps because they are seen as potentially more capable of dangerous and violent behavior.

Psychiatric characteristics of patients influence attitudes as well. People respond differently to various types of symptoms. In general, physical symptoms, such as headaches, are more respectable than behavioral ones, such as tics and phobias. Least acceptable are symptoms which seem bizarre, mysterious, rationally inexplicable, or beyond the realm of ordinary behavior, like hearing voices or acts of self-mutilation. More visible disturbances are more readily rejected than inconspicuous behavior, regardless of their relative effects on the patient's ability to function. Similarly, families are more likely to hospitalize relatives whose behavior is socially embarrassing than those who are not noticeable, other factors being equal.

Characteristics of the treatment situation, such as site, method, frequency, and therapist type, also affect attitudes. With respect to site of treatment, hospitalization is more stigmatizing than outpatient care. A history of hospitalization may be a handicap to the ex-patient seeking school admission, employment, and housing, although recent data suggest that premorbid occupational status, not stigma, is the major determinant of postillness occupational achievement. Private mental hospitalization is less stigmatizing than public hospitalization, as is private outpatient care in contrast to use of public clinics. Even among mental health professionals, a history of hospital-

ization influences relative willingness to rehospitalize, to accept for outpatient care, or to undertake certain forms of psychotherapy (Rabkin 1977). With respect to method of treatment, physical methods, such as electroshock, are more stigmatizing than verbal psychotherapy, and individual treatment is regarded as an index of more "serious" disorder than group, marital, or family therapy.

The person administering treatment influences attitudes as well. It is generally assumed by the public that more highly trained professionals treat more seriously disturbed patients. People are more apt to regard a person who sees a psychiatrist as mentally ill than one who sees a psychologist or social worker. Today few would label a person as mentally ill just on the basis of having seen a marriage counselor, minister, or family doctor for emotional problems (Rabkin 1979). In fact, the public's opinion on this issue is largely incorrect; for the most part, the most highly trained professionals actually treat well-educated, well-off, and not very sick patients, particularly in private practice.

Regarding frequency of visits, there is also a discrepancy between public and professional opinion; to the public, greater frequency signifies greater pathology, while the converse is generally the case in practice.

CHARACTERISTICS OF RESPONDENTS THAT INFLUENCE ATTITUDES

Demographic variables, such as age, education, social class, and ethnicity, have been studied in this context. Older people are found to be less tolerant than their younger counterparts, more concerned about dangerousness, requiring more social distance, and knowing fewer people personally who have been mentally ill. Higher social status is associated with more tolerance of deviance, including mental illness. The poor are said to be more often conservative in medical matters and usually favor having mental illness treated as a physical illness. Lower class members are more apt to regard deviant behavior as bad and serious but not ill. Once the label is assigned, they are more rejecting than higher status groups. No clear-cut differences due to race have been identified. With respect to ethnicity, the more acculturated groups express greater tolerance

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than the most recently arrived (e.g., Puerto Ricans, Spanish-speaking Mexicans).

Experience with mental patients makes some difference in attitudes. Personal acquaintance (family, friends, network members) is hard to measure as a separate effect since some tolerance is required to acknowledge knowing socially someone who is mentally ill. In general, *personal* acquaintance is associated with greater acceptance. Contact with mental patients who are not personally known is not as effective in promoting favorable attitudes. Those motivated to change (college students, nursing students) do indicate greater acceptance after such contact. Other people are not likely to change significantly. On the other hand, contact with patients in normal or cooperative roles (e.g., camping trips, hospital guides) does influence attitudes favorably. Additional information about mental illness helps up to a point. When people are able to differentiate among levels of mental illness, they are more accepting of mild conditions. Attitudes about mental illness are related to other beliefs. For example, people who are intolerant of mental patients have little sympathy for other forms of deviance, are more often politically conservative, and are more authoritarian in their general outlook.

In summary, the extent of public rejection or acceptance of mental patients is influenced by the personal and psychiatric attributes of the person described as deviant, by the nature of the treatment situation, and by characteristics of those who are expressing their attitudes.

ATTITUDES AND BEHAVIOR

Among investigators of attitudes toward mental illness, it is commonly suggested or implied that attitudes are precursors or determinants of actual behavior. Many studies are based on a very simple model of behavior in which a unitary attitude is expected to correspond to a single action. Such assumptions about the association between attitudes and acts are not generally supported by observation. Knowledge of a particular attitude seldom leads to correct prediction of a specific act. However, in view of the vast numbers of attitudes each person harbors about various issues, the array of situational factors inevitably present in any setting, and difficulties in selecting the

salient attitudes and behaviors to measure, the lack of success of such predictive efforts is not surprising.

Even when attitudes are measured accurately, they are seldom the major determinants of behavior. More influential are personal and situational factors. Personal factors include other attitudes, values, and competing motives. Situational factors encompass the influence of other people, social norms, and expectations, and the number of alternative behaviors possible in a given setting (Eagly and Himmelfarb 1978). For example, even with strong negative feeling about mental illness in general, an employer is likely to hire a former mental patient who can do the job, if there are no superior or equally qualified applicants, if the job must be filled soon, or if the applicant is perceived as an acceptable person, or as one who had a "nervous breakdown" rather than a "mental illness." Attitudes may be expected to influence behavior but are unlikely to show a direct correspondence with actions.

GOALS OF PUBLIC EDUCATION

Members of the public will probably always have some reservations about mental illness and proximity of the mentally ill. It would be unrealistic to expect otherwise for several reasons. First, if people saw nothing objectionable about mental illness or the behavior of the mentally ill, they would not spend millions of tax dollars annually to treat mental illness. Second, those patients who are most apt to be visible to the community tend to be handicapped not only by deficiencies in social judgment and social supports but often by the futher burdens of low-social status and meager personal resources. Further, the chronically mentally ill, especially those who have been hospitalized for substantial periods, are often conspicuously lacking in social graces, are indifferent to their appearance, and eccentric in their public behavior. On these grounds alone, apart from a fear about mental illness as such, they would be perceived as socially undesirable.

A third consideration is that *no* group is universally welcome in our very mixed society. Years ago it was found that even generally socially accepted subgroups were regarded with reservations by members of other subgroups. What kinds of acceptance can be expected of the mentally ill population with its disproportionate representation of low-status-social groups?

A fourth point concerns the level of acceptance of the mentally ill in relation to a more generalized tolerance of deviance of all kinds. It is unlikely that the former can be influenced without altering the broader network of community attitudes and values—a formidable undertaking.

Overall, it seems unlikely that people identified to the general public as mental patients by their appearance, manner, behavior, or even perhaps reputation, will ever be actively welcomed in close social or physical proximity. Through appeals to the public's enlightened self-interest, however, tolerance or understanding, if not affection, may be won.

Summaries of Workshop Papers

Lenore Gelb and Joyce B. Lazar

This section includes summaries derived from papers prepared for the workshop, as well as a summary of one previously published paper by Raymond Weinstein that was distributed at the workshop.* References from the papers, compiled to serve as a general resource guide, are listed on pages 65–73. The research recommendations are based on both the comments of the formal discussants and the general discussion that followed the presentation of the papers.

PERCEPTIONS OF MENTAL ILLNESS

Determinants of Public Attitudes About Mental Illness: Current Status and New Directions

Judith G. Rabkin

In summarizing past efforts, Rabkin points out that when research on attitudes toward the mentally ill was first undertaken more than 40 years ago, the two major concerns were how public attitudes influenced help-seeking behavior and how negative public attitudes retarded the reintegration of former patients into the community. Investigators believed that education programs could correct public misconceptions, thus encouraging help-seeking behavior and facilitating the reintegration process.

The majority of studies sampled members of the general public using interviews, pencil-and-paper questionnaires, or

*Copies of the entire papers may be obtained from the authors. Their addresses, as well as those of the other workshop participants, are listed on pages 75–76.

scales. The two most commonly used measures have been social-distance scales and vignettes. Some formal scales were developed more than 15 years ago, of which the most popular and psychometrically sophisticated is the "Opinions About Mental Illness Scale" (OMI) of Cohen and Struening. Formal scales generally have been used with students or mental health workers rather than general population samples. Rabkin points out that such scales need systematic revision to address contemporary mental health problems arising from deinstitutionalization.

Numerous investigators have attempted to identify expressed attitudes concentrating on three major sets of correlates: characteristics of respondents, patients, and the treatment situation.

Rabkin summarizes the findings of the past 25 years of research as follows:

- *Respondents* with less tolerance for the mentally ill are likely to be: male, older, less educated, less skilled occupational workers, of lower class, members of relatively recently arrived ethnic groups, and those who report less social contact with the mentally ill.
- *Patients* least tolerated are likely to have these characteristics: male, assaultive, of lower class, members of ethnic minorities, with relatively few social or family ties, with relatively visible disturbed behavior, and prone to display behavioral rather than physical symptoms.
- *Treatment situations* associated with negative attitudes are likely to be: inpatient facilities, public rather than private, and specialized facilities rather than general hospitals. *Negative attitudes* are particularly associated with longer treatments, frequent treatments, somatic treatments, and treatment by psychiatrists rather than nonmedical personnel.

The relationships between these correlates and attitudinal statements have been demonstrated repeatedly with different samples so that there is little doubt about their reliability. However, the *magnitude* of the relationship generally is low. Were multiple regression analyses to be applied, Rabkin predicts that these three sets of attitudinal variables, even in combination, would be unlikely to account for a great deal of the variance in expressed attitudes.

Given the low-predictive power of these variables with respect to expressed attitudes, Rabkin sees little likelihood that they can predict behavior usefully, given the generally weak link between attitudes and behavior. It would be more effective to try to predict the "disposition to act" in a specific setting than to attempt to predict attitudes about a *concept* such as mental illness. For example, people who express negative attitudes toward mental illness might be reluctant to seek psychiatric help. However, their disposition to act might well be influenced by such contingencies as availability of services, cost and insurance coverage, knowledge about and distance to the nearest facility, acuteness and severity of disorder, extent of functional impairment, and personal and social supports and resources.

As Rabkin points out, the evidence indicates an inverse relationship between expressed *attitudes* and actions. Those *characteristics* that predict greater tolerance (higher educational level and higher social, occupational, and income status) also typify communities that effectively resist the establishment of psychiatric facilities. Liberal attitudes and kind thoughts seem to be offset by more potent factors, such as political power, and concern about real-estate values. Psychiatric facilities are more generally located in marginal neighborhoods where expressed attitudes are more negative but community resistance is not effective. In summary, Rabkin concludes, "It seems unlikely that further analyses about the general concept of mental illness will furnish useful information in planning programs of intervention and in implementing current treatment policies." What is needed now is new research directions.

RESEARCH RECOMMENDATIONS

- The consensus at the workshop was that there was little to be gained by using such undefined terms as "mental illness" and "mental patient." There is no way of knowing what respondents understand about these terms used by researchers. Often a gap exists between respondent attitudes and behavior. There is evidence that the term "mental patient" evokes maximally negative attitudes unless the term is clarified by more details about the patient's characteristics. Future research should either query respondents for their interpretation of terms used or should provide more specific

information. For example, in using the term "ex-mental patients," it would be useful to differentiate among persons who are completely recovered and asymptomatic; chronically mentally disabled but stabilized patients without acute symptoms; and persons who still exhibit acute symptoms.

- Too little systematic inquiry has been made into the public's beliefs concerning the etiology, course, treatment efficacy, and outcome of mental illness. We might expect beliefs to vary widely among individuals of different racial and ethnic groups, age and educational levels, and personal experiences. We do not know the extent to which popular conceptions are congruent with current professional beliefs, theories, and research findings.
- Further research is needed on the public's ability to identify psychiatrically disturbed behavior and, once the behavior is identified, their willingness to seek or refer others for services. Such questions, when linked to behavioral intentions, can yield information about personal as well as perceived attitudes.
- Studies should sample different influential subpopulations, such as community leaders, legislators, lawyers, judges, teachers, personnel directors, and newspaper reporters, to assess their attitudes and behavior toward the mentally ill.
- Research in this field has not been cumulative, in part because so many investigators have generated ad hoc questions and measures which have not been replicated. At present no up-to-date, reliable, and valid instruments are available to measure attitudes and dispositions to act in personal relationships. In addition, no valid instruments exist to measure the tendency to act in response to the placement of community facilities. An immediate priority should be the revision of sound but outdated old measures and instruments and the development of new ones.
- The move toward deinstitutionalization means that ever-increasing numbers of the acutely disturbed and the chronically mentally ill are expected to be absorbed by local communities. Because policymakers and politicians respond to public attitudes, it is important to document the range of community responses to these populations. Evidence shows that opponents of deinstitutionalization are a more powerful community force than proponents. Accurate information is

needed to assure that the level of resistance is not exaggerated because of a vocal minority.

- Overstatement of the existence of negative attitudes toward mental illness may be counterproductive. Such exaggeration may actually reinforce rather than diminish negative attitudes. Research should be done on the epidemiology of tolerance, on the one hand, and of rejection of the mentally ill, on the other.
- It would be useful to know more about how patients and their relatives respond to the various stages of mental illness.
- Longitudinal as well as cross-sectional studies are needed on the development of children's attitudes toward mental illness. Some important questions are: At what age do children become aware of mental illness as a distinct entity? How do their reactions evolve toward visibly deviant people in general and toward psychiatrically impaired children and adults in particular? What, if anything, do parents teach their children about mental illness? What are school programs teaching children about mental illness? What could they be teaching? How do children differ in their responses when they have had contact with the mentally ill? And what are the attitudes of children who themselves have had contact with mental health treatment personnel?

The Family, Stigma, and Help-Seeking in Severe Mental Disorder

John A. Clausen

John A. Clausen has done a long-term study of the impact of severe mental illness on the family. Since severe mental disorders are often first manifest in the family without the ill person's being aware of the problem, family members must play an important role in help-seeking. Clausen asks why delayed help-seeking occurs. One possible reason is that the family might be reluctant to recognize the severity of the problem. Another reason might be "the negatively viewed implications of requiring psychiatric help," often referred to as "stigmatization."

Since fear of stigmatization may play a major role in the family's reaction to mental illness, Clausen examines what the

term "stigma" means. Although the primary dictionary definition of stigma is "a mark of disgrace or infamy," the term is often used to connote any negative attitude or discriminatory behavior toward the mentally ill. He states, "My own research leads me to question whether most members of the population regard mental disorder as anything approaching a stigma. It does not, however, lead me to question that mental disorder is negatively evaluated or that fear of stigmatization is widespread among the mentally ill and their families." However, using the term "stigma" "arouses more emotional reaction than words like 'devaluation' and 'discrimination'" and does not encourage precise understanding of the nature of the responses to mental illness. According to Clausen, "To blame the devaluation of mental illness on stigma is to ignore the nature of mental illness. I have not heard of any society which in general regards or regarded madness to be as acceptable as responsible self-control."

Clausen summarizes findings from his long-term research on the impact of mental illness. Families were studied in which one spouse had been hospitalized for mental illness. Some of the families were first studied in the 1950s and then followed up in the 1970s. He reports that in those 20 years, "It appears that there has been a significant decrease in the expectation of negative reactions from others whom one knows." In the 1950s, one-third of the wives of mental patients tried to conceal the fact of their husband's hospitalization, another one-third were open about it, and the remaining third were reluctant to let others know but were less inclined toward complete concealment. In the 1970s, relatively few spouses tried to conceal hospitalization, but one-third limited their communication about it.

Those spouses who chose to limit communication were also "less likely to interpret the patient's early symptoms as evidence of mental disorder, attributing them more often to upsetness, stress, or physical illness." In short, such spouses appeared more likely to deny the illness, both to themselves and to others, although they sought help as quickly as those spouses who communicated more freely. Clausen also found that a close emotional tie between spouses is associated with one partner's reluctance to define the other as mentally ill. However, once

the disturbed person has been finally diagnosed as mentally ill, many of their spouses expressed relief.

At followup, 15 to 20 years after the initial Clausen study, two-fifths of the couples were divorced. A majority of the patients, both divorced and still married, had experienced recurrences of severe mental disorder since the first study. A considerable number of the patients who remained married were reported to be functioning at least as effectively as they had in the previous 10-15 years. However, of the divorced group, many were functioning only marginally, if at all. Recurrence of symptomatology seemed to trigger marital termination; marital satisfaction prior to the illness did not seem to affect the divorce rate. Interestingly, there was little relationship between continued symptomatology and divorce in the case of female patients, but a strong relationship in the case of male patients. In Clausen's view, "Relatively few women wish to remain married to a man who cannot function effectively in an occupational role." Another sex difference he found is that men are much less likely than women to seek treatment, or to participate in the decision for rehospitalization and are more likely to be committed. Perhaps, he feels, men fear stigma more than women.

Clausen reports that very few of his respondents used the term "mental illness." Few men or women boasted that they had been hospitalized. If symptoms did not recur, the period of illness was likely to be labeled a time of "emotional upset" or a "nervous breakdown." Clausen points out that there are very few patients or spouses who do not feel apprehensive about others' reactions to mental hospitalization. Yet, as he notes, "The great majority of men who had been employed in a job for more than a year prior to hospitalization not only found that their jobs were available but returned to them." Co-workers tended to be perceived by ex-patients as oversolicitous rather than hostile or aloof. According to Clausen, former patients' ability to perform on the job dispelled any self-doubts they might have had. Ex-patients and their families reported few actual experiences of rejection outside the occupational sphere. For example, when the children of mentally ill parents are interviewed, they say that most of their friends are sympathetic and understanding. Further, over the long run, very few children seem to reject a mentally ill parent, especially a mentally ill mother.

Clausen also has studied fears of stigmatization and their influence on help-seeking in families where a child is the patient. He cites findings by Lum that few parents were willing to seek consultation until their child's behavior had become very difficult. Clausen asks whether this is another example of delayed help-seeking caused by a fear of stigmatization. If such parents are to be helped in the future, more research is needed to understand parents' reactions to mental illness in their children.

In Clausen's view, "The former patient's fear of rejection, coupled with uncertainty about the ability to function in normal roles, is a far more significant barrier to full social participation than is anything appropriately called stigma." Further, "Negative attitudes and emotions about mental illness do exist, but it is necessary to differentiate the forms and consequences of such attitudes for various aspects of patient care and rehabilitation." And, finally, "Fear of loss of control is certainly a major source of anxiety for many people. To deny that such fear exists or to attribute it to 'stigma' is to avoid an adequate analysis of the social meaning of mental illness."

RESEARCH RECOMMENDATIONS

Despite longstanding professional concern about negative attitudes toward mental illness, little research has been conducted on the extent to which help-seeking is deterred for fear of stigmatization.

- Research is needed on the role played by the family in encouraging or discouraging help-seeking behavior. Such studies should examine the role of the immediate and extended family in encouraging treatment for adults as well as children.
- With the increase in single-person households, studies are needed to ascertain where such persons turn for social and emotional support as well as who encourages them to seek help when necessary.

Social Attitudes and Beliefs and Their Role in Mental Disorders

Amerigo Farina

Amerigo Farina presents a conception of mental illness which is more interactive in its perspective than some of the other papers presented. In his view, "Psychopathology might be a process involving the entire social situation in which the mental disorder is being manifested and observed." Farina's experiments support this view. His first systematic study that takes the social situation into account involved pairs of male college students in a laboratory situation. When one member of the pair was believed to have been hospitalized for a mental disorder, the other person perceived inadequacies in behavior which objectively did not exist. In other similar laboratory experiments, the pseudo ex-patient was perceived as less likeable and competent. Furthermore, task performance, objectively identical to the control condition, was perceived as significantly less adequate. To Farina these studies support the theory that behavior inadequacies, typically considered an objective component of mental disorder, are actually a product of the social situation.

As Farina says, "These studies have focused on the 'normal' and his contributions to a part, at least an apparent part, of the total phenomenon of psychopathology. But the 'normal' is not the only one involved in the interaction. The social attitudes and beliefs which make mental disorders degrading are probably more salient and important to the afflicted than the observer, and they may affect a blemished person independently of the way others act." To test this possibility, a laboratory study was done by Farina and his associates, again using pairs of male college students. This study was different from Farina's earlier studies in that the only independent variable was the subject's belief that he was perceived as normal or stigmatized. According to Farina, "The results unambiguously showed that merely believing they were viewed as stigmatized influenced the behavior of the believer and caused the other subject to reject them." Thus, "The study suggests not only that social attitudes and beliefs about mental disorders influence the behavior of the sufferer, but that the social rejection they encounter is, in part, caused by themselves."

Do people who really have been mentally disordered respond in the same way as the college students in Farina's laboratory studies? Farina explored this question using as subjects males who had been mental patients in a Veterans Administration (V.A.) hospital. The alleged situation was an employment interview. When the subjects believed the interviewer was aware of their status as ex-mental patients, they felt less appreciated, found the task more difficult, and actually performed more poorly than in the control condition. They were also rated as more tense, anxious, and poorly adjusted, even though the rater was unaware of their ex-mental patient status. Such characteristics often can indicate the presence of a mental disorder and yet, in these studies, they appear to have been produced by the immediate social situation.

As Farina's next series of research studies indicates, "Sex is a variable that will radically affect the role of social beliefs and attitudes in mental disorders." One study, with female subjects in a department store, was designed to discover whether workers would discriminate against a potential co-worker who was an ex-mental patient. Farina found that the clerks "indicated equal willingness to work with [the confederate] and saw the confederate as equally competent, whether they thought she was an ordinary job seeker or someone who had experienced a severe mental disorder." Further, when the female acting as a mental patient was nervous and tense, she was disliked, indicating the workers were not compelled to give the socially desired response. When the study was replicated with males in a V.A. hospital, Farina found that males strongly rejected and disliked the person acting as a mental patient. However, since a mental hospital is quite a different setting from a department store, Farina did another study to assess the role of the differences in settings versus the possible sex differences.

Farina found that female subjects at a V.A. hospital responded to someone they believed to be a mental patient in the same way as the department store clerks: They did not reject the person in the mental patient role, although the nervous person was rejected. Farina concludes, "The variable which accounts for the differences in rejection of people with a psychiatric history must be gender." To test this theory further, Farina did a similar study with the female workers but used a male confederate mental patient. The results were identical to the two

prior studies of female subjects. Other studies with male subjects further confirmed that men are more rejecting of people viewed as mental patients, even when the patients are female.

Thus, Farina finds "a clear sex difference in responses accorded those who have been afflicted with mental disorders. At least in some conditions, males behave more harshly and are more rejecting of such individuals than are women." Farina speculates that "the distortions of perception, the harsh treatment accorded sufferers, the job discrimination, and the increase in symptoms by an ex-patient who believes his status is known, all may occur only for males." Farina finally asks whether these sex differences might reveal something new about the nature of mental disorders.

In summary, the series of studies conducted by Farina has indicated that the social situation influences the behavior of both the person perceived to be a mental patient and the person making the judgment. A person who believes he or she has been identified as a mental patient behaves in a way that elicits a negative response. Such a response was found both in the laboratory and in a naturalistic setting. However, Farina found that women are far more accepting of persons identified as former mental patients than are men.

RESEARCH RECOMMENDATIONS

- Systematic research on the effects of the social situation on interpersonal perceptions in actual life settings should be continued. The effects of age, sex, race, and social-class differences of ex-patients on interpersonal perceptions should also be explored.

Assessing the Sources of Perceptions of the Dangerousness of the Mentally Ill

Henry J. Steadman

Current conceptions of mental illness must be delineated better if intervention is to modify them effectively. Research shows that the mentally ill in general, but especially men, are perceived as dangerous. Henry J. Steadman discusses the public's fear of the mentally ill, the basis of these fears, and what to do about them. As he reports, "Recent research data on the behavior and characteristics of contemporary populations of ex-

mental patients support these public fears to an extent rarely acknowledged by mental health professionals." According to Steadman, the literature suggests that public perceptions of dangerousness stem primarily from the disturbed behavior of the mentally ill. While recent data on the arrest rates of ex-mental patients support the public's fears, these data must be put into context. Follow-up studies of ex-patients from 1965 through 1978 revealed that mental patients had arrest rates higher than those of the general population, especially for assault and robbery. For violent crimes, former patients were arrested three times as often. Steadman states, "Our data and all other data from 1965 onward unequivocally show that persons released from State mental hospitals are arrested more than the general population." The key to these increased rates of arrest of ex-mental patients is the "increasingly large proportion of patients in State mental hospitals who have prior arrest records."

It is important to note that released patients who had no prior arrest records were less likely to be arrested than the general population. The public, however, appears to respond to anyone who is released from a State mental hospital as likely to be dangerous, without regard to prior police record. Even though only a very small percentage of released patients are arrested for violent crimes, the public's perceptions are based on these few instances.

Still, it remains true that as a group, ex-mental patients have higher arrest rates than the general population. One reason is the trend toward early discharge of patients. The age of persons being discharged from State mental hospitals is decreasing. This is significant in that younger persons have a greater probability of arrest. Steadman explains, "When the average age of released mental patients steadily decreases, especially from near 40 to close to 30 while the proportion of patients with prior arrests increases, one would expect that the arrest rates would continue to increase, further exacerbating differences with the general population rates." As Steadman concludes, "It appears time to acknowledge there may be a kernel of accuracy in the public's depiction of the mentally ill as threatening and dangerous, if arrest rates greater than those of the general population are assumed to indicate dangerous behavior."

Although mental patients might have higher arrest rates than the general public, public mental hospitalization is still a relatively infrequent phenomenon. Steadman reports that in 1975 there were but 32 admissions per 10,000 people to State and county mental hospitals in the United States, and many of these were the same persons being admitted two or three times. With such low rates, the prime determinants of public perceptions will not be direct contact with ex-patients, as Steadman points out. What the public knows about the mentally ill is mostly garnered from the media, not always accurate sources of information.

What are the consequences for public policy and public education in acknowledging that mental patients as a group may be more dangerous than the general population? The news media will probably continue to exaggerate the dangerous potential of the mentally ill. Thus, according to Steadman, public education programs geared to changing perceptions of the mentally ill must begin to acknowledge the extent to which ex-mental patients are involved with the police. Futher, as Steadman points out, "There is a certain element of increased risk to the community from ex-mental patients unless we are willing to place in community programs only older patients and those with no prior police records." Since that strategy does not appear desirable or feasible, Steadman suggests that an alternative action may be to accentuate the positive (or absolute rate of arrests) and eliminate the negative (the relative rate of arrests) in public education.

When examining negative attitudes toward the mentally ill, Steadman feels that the essence of stigma is fear. In his view, one way to reduce that fear is to increase the public's exposure to and contact with ex-patients. Furthermore, mental health professionals should acknowledge the limited validity of the public's perception of threat and danger and address these fears directly in any public education campaign to change attitudes toward the mentally ill.

RESEARCH RECOMMENDATIONS

During the workshop discussion, the point was made that all the Steadman studies were conducted in New York. The extent to which these findings are generalizable is not known. Concern was also expressed about the limitations of using arrest

and/or conviction data as evidence for the dangerousness of mental patients.

- Research is needed to replicate Steadman's studies of dangerousness with a national sample. Care must be taken when comparisons are made to assure that controls are matched for prior arrest record.
- It appears that perceived dangerousness and unpredictability are the essence of negative attitudes toward mental patients. Data on criminal behavior of the mentally ill are unreliable for a number of reasons. Courts often have the option of either sending a defendant to a mental hospital or to jail. The frequency with which defendants are sent to mental hospitals varies across time and place. To understand better subsequent rearrest data after release to the community, research is needed on the basis by which such court determinations are made. Further, research is needed to assess whether former mental patients are more apt to be arrested for deviant behavior which might be tolerated in others.
- Arrest records alone are not sufficient to assess rates of dangerousness. There is a need for research which examines the full spectrum of patients in public and private and in- and outpatient facilities.

INFLUENCES ON PUBLIC ATTITUDES TOWARD MENTAL ILLNESS

A Commentary on Studies of the Patient's View of the Mental Health System

Nancy E. Waxler

Nancy Waxler comments on patients' views of the mental health system and methods used to measure these views. Earlier studies surveyed by Waxler were concerned with patients' attitudes toward psychiatric hospitals. More recently, she reports, research has shifted toward patients' evaluations of clinic and community mental health services. According to Waxler, the lack of a standard methodology has weakened the more recent research.

The earlier social-psychological studies typically reported that patients had negative attitudes toward the hospital in

which they were treated. Waxler also reports that patients rated hospital services more positively than they did the staff and other patients. In addition, Waxler reports that in such studies patient attitudes were influenced by their own psychiatric backgrounds and the social context of the wards. If the social milieu of the ward created more support, affiliation, and involvement, patients tended to be more satisfied, regardless of their individual characteristics. Looking at the early research, Waxler finds, "There is clearly an attempt to specify patient views as well as to search for the sources of generally negative attitudes toward psychiatric hospitals."

Waxler describes the methodology in these earlier attitude studies. Some research designs "mixed the effects of attitudes toward psychiatric hospitals in general—usually negative—with attitudes that had been molded by specific experiences on specific wards—sometimes positive." According to Waxler, in comparison with later research, these studies showed concern for sampling issues, for example, probability sampling methods were used, data on sample loss were provided, and checks were made for sampling bias. Relatively sophisticated measuring instruments were used including agree/disagree attitude scales and semantic-differential techniques. Two assumptions underlying these studies, according to Waxler, were that patient attitudes are individual phenomena, determined by current individual experiences or social background, and that the medical model of disease is valid. As Waxler observes, "While the underlying model [of these earlier studies] tended to take the psychiatrists' goals for granted, findings from these studies were strong enough that general principles about what patients see as 'positively valued hospital service' could be drawn from them."

Recent research has shifted to investigate "consumer satisfaction" with community care as opposed to patient attitudes to hospital care. As Waxler asserts, "In sharp contrast with negative attitudes toward the treatment system reported in the earlier studies, many recent consumer-oriented studies show very high rates of patient satisfaction." However, the source of these positive evaluations is unclear. One source could be the fact that, according to Waxler, "Most consumer satisfaction surveys are carried out by staff members within the clinic," making the patients reluctant to express negative attitudes.

Waxler cites haphazard selection of patient samples as another possible source of bias. In addition, instead of using relatively sophisticated instruments to measure attitudes, these consumer satisfaction studies relied on single questions of unknown reliability and validity.

In Waxler's view, "Most of these methodological problems stem from the fact that 'consumer satisfaction' research is seldom informed by an explicit theory." Therefore, "Consumer-oriented research findings remain specific to a particular clinic context and do not add to our body of knowledge about patients or clinics in general." Instead, most consumer satisfaction studies serve to confirm the "general assumptions of the physician as to how treatment should be offered and who should make decisions about services." As Waxler notes, "It is probably impossible for these studies to discover significant aspects of the patient experiences in the treatment system."

Waxler questions the utility of outpatient attitude surveys altogether and suggests that, instead, it would make more sense to study patients' actions. For example, she suggests studying "which prospective patients use the system and which do not; who tries and does not succeed; who drops out, moves on, stays." Further, she suggests studying how some treatment systems contribute to the stigmatization of patients by the treatment process itself. As her preliminary findings suggest, "The way in which a hospital is organized leads to a particular kind of social processing of psychiatric patients such that patients leave the system with the self-definition of impairment and an expectation that they will not or cannot be 'normal.'"

Waxler concludes that as interest in patients' attitudes has increased, the quality of research has decreased. As she suggests, "Rather than asking patients how they feel about the clinic and its services, it may be more useful to examine the ongoing interactions between patients and clinic staff in order to understand how some hospitals and clinics unintentionally contribute to chronicity and to the stigmatization of psychiatric patients."

Patient Attitudes Toward Mental Hospitalization: A Review of Quantitative Research

Raymond Weinstein

In a published paper not given at the workshop, Raymond Weinstein presents a different view of past research on patient attitudes toward hospitalization. He describes much of the research as qualitative, based on observation, on informal interviews, and sometimes on having social scientists masquerading as patients. The results of such qualitative studies reveal that patients have negative attitudes toward hospitalization. Weinstein questions the findings. As he notes, "Seldom have social scientists taken representative samples of patients, questioned them directly about the hospital or their illness, utilized objective tests, or validated scales and presented the findings in statistical format." Weinstein believes one reason for this lack of interest in systematic study of patients' views stems from researchers' bias toward a "tacit acceptance of the medical model of mental illness," which implies that patients who are considered ill are likely to have unreliable opinions.

Weinstein examines and reviews the few quantitative research studies of patient attitudes toward mental hospitalization. As he has noted:

> Results indicate that in 30 of the 38 different samples tested, or 78.9 percent, patients espoused favorable attitudes. Patients proved to be somewhat more favorable in their attitude toward mental hospitals in general than their own institution, and patients in university hospitals tended to express more positive views than those in either State or veterans' hospitals. A content analysis of the attitude measures reveals that a hospital's treatment, restrictions, organization, and amenities were rated more favorably by patients than its staff and other patients. Limited data suggest that patients' opinions of their own institution, but not of hospitals generally, change for the better between admission and discharge. Studies that compared patient and staff attitudes have inconsistent findings. Social variables had a negligible effect on the favorableness of patients' responses, but the impact of psychiatric variables was considerable.

As Weinstein concludes, "The picture of institutionalization drawn by patients bears little resemblance to the one sketched

by the critics of mental hospitals." This disparity in the perceptions of hospitalization might stem partly from the fact that patients and researchers view the hospital experience from totally different vantage points. Researchers, posing as patients in an attempt to evaluate the effects of hospitalization, are not mentally ill and are "therefore not in a position to benefit from treatment and cannot possibly perceive their experiences in the same way as do bona fide patients." Also, Weinstein suggests, qualitiative researchers' theoretical orientations lead them to assume that "basic changes in patients' self-concept must occur, that the hospital forces people to perceive themselves as mentally ill and adopt a pattern of disturbed behavior." Patients have positive attitudes toward hospitalization for a number of possible reasons. One reason could be that the hospital can be a "temporary haven." More important, for some, "hospitalization seems to represent an opportunity for self-improvement."

Weinstein has several suggestions for future quantitative research on patient attitudes. First, "The validity and reliability of the data collected should always be checked and reported." Second, "It would be useful if the same attitudinal measures were given to patients in more than one type of institution," allowing more systematic comparisons among patients being treated. Third, future investigations should consider the type of commitment—voluntary vs. involuntary. Fourth, researchers should study patient attitudes over time (e.g., at admission, discharge, and followup) to discover attitudinal changes due to hospitalization.

In contrast to Waxler's view, Weinstein stresses the importance of continuing to study patient attitudes. Such research has clinical value for therapists and practical value for program planners. In addition, Weinstein points out, "Data on mental hospitalization from the patient's perspective have theoretical relevance for sociologists and psychologists in their studies of self-concept, formal organizations, sick-role behavior, socialization, and interpersonal relations."

RESEARCH RECOMMENDATIONS

- It is important to continue to study patients' reactions to treatment and the treatment system. Ways must be explored that involve patients in the planning and evaluation

of mental health services. Failure to include patients and ex-patients as part of the evaluation team can cast doubt on the validity of the findings.

- In evaluating patients' reactions to treatment, it is important to consider the type of treatment and the setting: outpatient vs. inpatient, voluntary vs. involuntary.
- Since patients' attitudes may change over time, it is relevant to study their reactions while they are in treatment, after discharge, and at followup.

Stigma: Social Functions of the Portrayal of Mental Illness in the Mass Media

George Gerbner

The media have an impact on public attitudes toward mental illness. George Gerbner describes the role of the media in perpetuating negative attitudes and stereotypes of the mentally ill. Gerbner first describes how cultural images interact with public perceptions of deviance. To the extent that the mentally ill violate social norms, they are grouped with other deviants and suffer consequences. Futhermore, he says, "As long as the culture cultivates inequities as the norms of society, the mentally ill, along with other potential norm-violators, will be stigmatized by culture." According to Gerbner, specific symbolic manipulation (which can be called either "stereotyping," "prejudice," or "stigmatization") is required to make people accept social and power inequities. Stories of crime and violence are particularly suitable for the portrayal of deviants and the price they pay for breaking the social norms. These stories act to "mobilize popular support for control measures and, if necessary, for the repression of threats to the social order."

The cultural images of mental illness in the media reflect traditional prejudices. A predominant image of the mentally ill is one of unpredictability. As Gerbner points out, "If you cannot predict how people might behave, you cannot be expected to act considerately and rationally toward them." A second critical aspect of the image of mental illness is dangerousness. The sense of dangerousness, according to Gerbner, is constantly reinforced by having the label "ex-mental patient" attached almost exclusively to violent and bizarre behavior. The third aspect of the cultural image of mental illness is a sense of evil.

Gerbner's explanation is that sinful or immoral behavior warrants an irrational and brutal response toward the persons depicted, as if to suggest that they ask for it or deserve it.

Gerbner found in his studies that media images of the mentally ill are more in line with the traditional prejudices than the actual characteristics perceived by mental health professionals. Unpredictability, dangerousness, and evil characterize the mentally ill in popular fiction, news, and other materials. He describes news coverage, and how it can perpetuate stereotyped images of the mentally ill. According to Gerbner, murder and violence are selling points for newspapers. Characteristics of killers most often include insanity, unpredictability, and the victimization of ordinary people. Gerbner cites studies that demonstrate selective reporting and can cause subsequent public misconceptions. A survey of 413 households asked respondents to name people who are criminally insane, without defining the term. All those named were murderers—many, mass murderers. Actually, as Gerbner points out, "The term 'criminally insane' legally means being insane at the time of the crime and thus incompetent to stand trial in a felony case. The vast majority of the 'criminally insane' commit crimes against property and other minor offenses. Only 14 percent have even been accused of murder."

Since 1967, Gerbner has done studies of television network dramatic content. He finds that 10 percent of the programs involve mental illness, and 2 percent of the major characters (4 percent in late evening) are identified as mentally ill. Forty percent of all prime-time "normal" characters are violent, but 73 percent of the mentally ill characters are violent. In addition, almost twice as many of the mentally ill characters on TV are victims of violence.

A mentally ill female character has a 71 percent chance of being portrayed as violent, while "only" 24 percent of all prime-time female characters are violent. Gerbner cites statistics related to victims of crime also. For every 10 normal male victims of violence, there are 17 mentally ill male victims; for every 10 normal female victims, there are 25 mentally ill female victims. Upper and lower class characters are more likely to be portrayed as mentally ill than are middle-class characters, and thus are more prone to violence and victimization. Occupations portrayed with the most mentally ill charac-

ters include manual laborers, scientists, clerical and sales people, as well as criminals. Less mental illness is found among the occupations of proprietors, police officers, farmers, and ministers. As Gerbner has shown, "The vast majority of mentally ill characters on TV . . . are not only dangerous, but also are touched with a sense of evil that justifies mistrust and eventual victimization."

In short, Gerbner believes that the media set the norms for society as well as the price for deviance. The mentally ill, according to Gerbner, "is a stigmatized group that serves as a lightning rod for [viewers'] pent-up insecurities and, at the same time, demonstrates the moral and physical price to be paid for deviance." Gerbner suggests that research efforts should trace images of mental illness in the media over time, while also tracking viewer conceptions cultivated by these images. As he states, "Systematic, cumulative, and periodically reported information about the cultural sources and functions of popular conceptions of mental illness can provide the basis for new judgments and decisions in cultural policy."

RESEARCH RECOMMENDATIONS

- We should continue to refine the investigation of the mentally ill as they are portrayed on television and in other media to determine the influence of such portrayals on public attitudes.

Law and Attitudes Toward the Mentally Ill

Bruce D. Sales

Bruce Sales is interested in understanding how laws affecting the mentally ill influence attitudes and behavior. Describing the potential impact of the law he says, "Laws affecting the mentally ill may have a tangible effect upon the attitudes of the person who is the subject of these laws, the legal and mental health professionals who carry out the law's mandates, and the family, friends, and community residents who form the social environment of the person." Further, as Sales points out, laws can change attitudes toward the mentally ill in both positive and negative directions. Sales finds it important to identify the legal variables that contribute to negative and inappropriate attitudes toward the mentally ill.

Legal terminology is one obvious example of a legal variable that can contribute to negative attitudes. The standard legal use of such terms as "incompetency to stand trial," "idiocy," and "lunacy" may contribute to negative attitudes. Sales suggests that research could identify those Federal and State laws that contain language that attaches negative labels to mentally ill persons. Once these laws are identified, their impact on the person who is labeled, as well as other individuals, such as lawyers, judges, family members, and friends, should be assessed. One research study cited by Sales suggests that attorneys specifically trained to represent their clients in commitment proceedings did not stand up aggressively for their clients. Terms such as "mental illness" often "have very specific and different meanings in the law than either the mental health professional or the lay public would ascribe to them." For example, the legal term "incompetent to stand trial" implies a permanent illness when, in fact, a more accurate term might be one like "unable to stand trial" which implies the problem is temporary. As Sales suggests, "Programmatic research on the impact of the various terms, both those currently in use and those not currently in use, could help to minimize the negative influence of future laws."

Various legal procedures can also influence attitudes. Sales again uses the example of "involuntary commitment" to make the point that "The law represents a compromise that balances protection of the person and society against the rights of the individual." On this basis, the court decides whether rigorous due process should be followed or whether the person needs emergency hospitalization that might appear to ignore the person's rights. What is not known is which procedure is most likely to generate negative attitudes. Other procedures that may affect attitudes negatively include guardianship/conservator laws which often do not allow the person who is subject to the law to be present at the court hearings. Another relevant issue related to legal proceedings involves the enforcement of laws. Are more negative attitudes created by enforcement agencies that are visible, such as local police departments, or by less visible agencies such as the Department of Labor? The answer to these questions is not known.

Legal procedures can influence attitudes in other ways as well. One issue concerns patient advocacy, which encompasses

a broad range of potential services for mentally ill clients. With so many alternative services, it is important to choose the most appropriate service for each individual. It is also important to know which service is likely to engender negative attitudes. As Sales points out, "Certain forms of advocacy might generate negative attitudes but might still be worth doing because of a positive outcome . . . We need to understand the personal and social costs and benefits that are incurred in trying to achieve a particular outcome." The goal is to find alternative actions that comply with the laws and are most likely to create a positive outcome for the person and society.

Some types of laws tend to have more impact on attitudes than others. For example, the insanity defense probably affects the public's attitudes more than other laws because of its notoriety and not because of its frequency of use. Whether a law is classified as criminal or civil might also affect attitudes. Another set of variables concerns how laws are written. For example, should laws relating to the mentally ill, such as antidiscrimination laws, be separate from antidiscrimination laws relating to alcoholics?

To approach the problem of the law and attitude change from another direction, Sales asks how attitudes can influence laws. Attitudes of legislators can, for example, affect the choice and enactment of mental health laws. The attitudes of legislators are affected, in turn, by the existing attitudes of lay and professional persons involved in law reform. Thus, it is important to know who has what negative attitudes and why. Sales asks these questions: "Will it be more effective to try and change attitudes before you enact the law, or is it better to enact the law and then engage in activities to promote understanding, attitude conformance, and behavioral compliance, or some combinantion of both?" "What public education techniques are most effective in achieving law-related attitude and behavioral change?" "How can laws be written to effect optimum compliance?" The final goal is "to enact laws that may be able to play a positive role in minimizing negative attitudes toward mental health and ex-mental health clients."

RESEARCH RECOMMENDATIONS

- A paucity of research exists on the relationship between law and public attitudes. Research is needed on how public atti-

tudes are affected by such commonly used legal terms as "incompetent to stand trial," "insanity," "idiocy," and "lunacy."

- Research should address: 1) the status of review and termination procedures in restrictive mental health laws; 2) the differential impact of procedures on the probability of termination; 3) the impact of these probabilities on the attachment and longevity of negative attributions and attitudes.
- Research is needed to evaluate the impact of legal procedures, such as involuntary commitment, in order to develop a legal structure that engenders the least negative reactions while being maximally beneficial to the person and society.
- Numerous research questions surround the enactment of mental health laws. Among the general research questions that should be asked are: When mental health laws are drafted, is consideration given to recommendations from mental health service providers and former patients as well as legal experts? Who chooses the terminology? Who decides how the laws should be classified? Whose attitudes are considered when laws are enacted?
- Research is needed on how laws can be written and categorized to best effect compliance. Dissonance theory would predict that more compliance would result from milder sanctions. Yet, the extent to which criminal or civil sanctions act as incentives to compliance is not known.
- Laws affect attitudes and, conversely, attitudes affect laws. Case studies are needed on the role of various groups such as legislators, professionals, and the public in the enactment of mental health laws. It is critical to study the existing attitudes of lay and professional persons to determine the locus of support for and opposition to appropriate mental health law reform.
- Research is needed to assess whether negative attributions associated with one group of people, such as alcoholics, are generalizable to another group, such as the mentally ill. Should laws be written generically, or should laws relating to the mentally ill be kept separate?
- Studies are needed concerning the applicability of psychological theories to the legislative process. For example, the legislative process would be an appropriate place to test hypotheses about impression-management theory. Whom do

legislators want to impress when they revise mental health laws and why?

- The relationship between attitudes and behavior is relevant to the question of whether it is more effective to try to change attitudes before enacting a law or to enact the law and then engage in activities to promote understanding, attitude conformance, and behavioral compliance. Research is needed on the effectiveness of public education programs in bringing about changes in population and subpopulation reactions.

COMMUNITY RESPONSE TO PSYCHIATRIC FACILITIES AND TO THE DEINSTITUTIONALIZED PATIENT

Public Response to Neighborhood Mental Health Facilities in Toronto, Canada

G. B. Hall

G. B. Hall and his associates have examined public response to deinstitutionalization in Canada. Hall relates that communities often oppose the introduction of community mental health services. The inner-city neighborhoods that more often tolerate ex-mental patients have the potential to become "psychiatric ghettos." As Hall suggests, "In order to plan for an effective geographical distribution of mental health facilites and thereby an effective service delivery, it is necessary to understand the nature of community reactions toward the mentally ill and deinstitutionalized forms of mental health care." Hall and his associates conducted a major study in Toronto to this end. Their paper reports on the design and selected results of their study, although this summary will concentrate solely on the results.

In the study of public responses to community mental health facilities, Hall and his colleagues consider three sets of factors fundamental: the physical and social characteristics of the host neighborhood; the attitudes of residents toward the mentally ill; and the characteristics of the facility itself. According to the investigators, "These factors work in combination to determine the fit between the facility and the neighborhood and, therefore, the acceptance or rejection of the facility by the host

community." According to Hall and his associates, community attitudes toward the mentally ill and attitudes toward the impact of community mental health facilities in residential neighborhoods are directly related to the success or failure of deinstitutionalized care in at least two ways. From the perspective of the ex-patient, the attitudes of community residents are important in determining their social integration, as Segal has shown. From the politician's or community planner's perspective, "Residents' attitudes are important in anticipating potential conflict situations resulting from the location of mental health facilities."

Hall and his colleagues report on the results of the community survey which focused on two separate, but related issues: community attitudes toward the mentally ill, and community attitudes toward mental health facilities in residential neighborhoods. In answer to the first question, respondents generally expressed sympathetic and benevolent attitudes toward the mentally ill, in contrast to the general assumption that community reactions to the mentally ill are negative. Although the variation in results by social class and geographic area was relatively small, Hall and his associates did find the lower socioeconomic class to be the least sympathetic and the higher socioeconomic class the most sympathetic. City residents were more sympathetic toward the mentally ill than people living in the suburbs, although the between-group differences were even smaller than among social-class groups.

In relation to the second question, according to the authors, good predictions of residents' judgments about facilities can be made on the basis of their expressed attitudes toward the mentally ill. People in the Toronto study were generally sympathetic toward mental health facilities in the community, although, as the authors expected, the desirability of the facility decreased with proximity to home. The most positive attitudes toward facilities were reported by the higher class city group and the least positive by the middle-class suburban group. In general, suburban residents rated facilities as less desirable than did their city counterparts. More evidence of community support is found in residents' attitudes to existing facilities, Hall and his colleagues point out. Only 139 of the 389 respondents living within a quarter-mile of an existing facility were aware of it, a significant fact in itself. Of the 139 respondents

who were aware, only 13 percent were opposed and another 14 percent were indifferent. As the authors state, "These figures, together with the relatively low level of awareness, give no indication of widespread opposition to existing neighborhood mental health facilities in Toronto."

The Toronto study does not support the assumption that community reaction to neighborhood mental health facilities is uniformly negative. For example, only 12 percent of the respondents rated as somewhat undesirable a facility location within seven to twelve blocks of their home. The percentage increased to 24 percent for the two- to six-block range and rose to 38 percent for locations within a block. These percentages are relatively low, even for the closest of the three distances.

Perhaps even more importantly, of the 13 percent of respondents who reported they were opposed to an existing facility, only 4 percent had ever taken any action to oppose the facility. It appears that behavior does *not* always follow attitudes. The authors conclude that people are generally tolerant but often unaware of facilities.

Neighborhood Types and Community Reaction to the Mentally Ill: A Paradox of Intensity

Steven P. Segal

The community reaction to the deinstitutionalized patient can have a strong impact on the patient's recovery. Steven P. Segal and his colleagues, James Baumohl and E. William Moyles, have explored the relationship between community types, the nature and intensity of the community's negative reaction toward the ex-patient, and the impact of that reaction on the ex-patient. Recently, researchers have attempted to identify the characteristics of accepting and rejecting neighborhoods. Segal and his associates use comprehensive descriptions of common characteristics in order to understand the social context of the community's reaction.

Segal, Baumohl, and Moyles look at "the impact of negative reaction on the social integration of sheltered-care residents housed in local facilities in different community types." They are interested in the patients' levels of external social integration, or the extent to which patients participate in community activities on their own, taking the individual characteristics of

each patient or resident into account. The neighborhood's impact, or community reaction, is judged by the extent to which the "community did not invite, or even discouraged the participation of community-care residents." It is described in terms of neighborhood "restrictiveness." Communities having sheltered-care facilities are described along five independent dimensions: political conservatism, family orientation, socioeconomic status, criminal activity, and degree of nontraditional orientation.

Five community types emerged, based on the foregoing dimensions: 1) average neighborhood, 2) liberal, racially mixed, working class, 3) conservative working class, 4) conservative middle class, and 5) liberal, nontraditional. Looking at different kinds of California communities in which sheltered-care facilities are located, Segal and his associates found that, in general, "California's sheltered-care neighborhoods appear to be among the most liberal, and perhaps the most tolerant in the State, but they also appear to be among the most vulnerable. Seventy-four percent of our sampled facilities are in neighborhoods of relatively low-socioeconomic status, with low-property values, high-crime rates, and, if voting frequencies are any indication, a pervading social apathy."

Segal and his research group evaluate the impact of neighborhood restrictiveness within different types of communities on the external social integration of sheltered-care residents and predict social integration by correlating it with level of community restrictiveness and levels of mental health services. They have found that facility residents in the most restrictive community type, the conservative middle-class neighborhood, have the lowest level of external integration. This finding was expected. However, as Segal reported at the workshop, they did not expect to find that "Levels of external integration are highest in liberal, nontraditional and conservative, working-class communities, even though the levels of restrictiveness in these neighborhoods are *moderate* rather than low." In spite of its moderate level of restrictiveness or negative attitudes, "The liberal, nontraditional community seems to provide a social context which is most conducive to higher levels of external integration," even after selection for individual resident characteristics is taken into account. As Segal relayed the thoughts of his research group, "The liberal, nontraditional neighborhood

may be the 'accepting' community which researchers have been seeking." The use of State mental health services was lowest in the liberal nontraditional community, the community with the highest external integration. This finding "is consistent with the notion that community services should enhance social integration."

Segal and his colleagues found that predicting external integration, taking individual characteristics into account, was possible in three of the five community types. In the conservative, middle-class neighborhood, restrictiveness, as perceived by the facility operator and the resident, is the most important negative influence on external integration. However, in the liberal, nontraditional and conservative, working-class communities, "Restrictiveness, although not extreme, is *positively* related to adjusted external integration." Segal and his co-workers postulate that this positive relationship is "a result of well-intended pressure" on facility operators, whereas in conservative middle-class communities, community reaction is "obdurate and pernicious, producing no salutory effects."

The relationship between adjusted external integration and the use of State services varies across community types. An unexpected finding was that in conservative, middle-class communities, that is, in restrictive environments, the use of State services was positively related to community adjustment or external integration. As Segal accounted for this finding at the workshop, "Rehospitalized individuals simply do not return very often, or very soon, to these highly restrictive communities, thus leaving a residual, more acceptable group of ex-patients who account for the positive relationship between the community's use of State services and the adjusted external integration scores of sheltered-care residents."

Segal considers it important to replicate the Segal, Baumohl, and Moyles findings in middle-class, conservative; liberal, nontraditional; and conservative, working-class communities. Also important is understanding "Why, even after controlling for selection factors, the sheltered-care population of the liberal nontraditional community has a significantly higher level of external social integration than found in any other community type." As Segal and his colleagues point out, "There are significant social costs involved in becoming a community which is safe for madness."

RESEARCH RECOMMENDATIONS

- Studies should identify the particular kinds of mental patients and inquire about the circumstances in which patients with various degrees of disability would be accepted in communities. We need to know what conditions, supports, resources, or incentives would make relatives willing to keep acutely disturbed or chronically disabled patients at home.
- We need to know more about the kinds of inducements communities require to provide a hospitable environment for a sheltered-care facility. Would increased police protection increase acceptance, or would simultaneous provision of another *desired* community facility be a more effective incentive?

Assessing Attitude/Behavior Linkages: New Directions for Mental Health Public Education Research

Richard C. Baron

Richard C. Baron believes that with the advent of the community mental health movement, a reexamination of the public response to the mentally ill is necessary. In his view, since public opposition can have a strong impact on the ex-patient's reintegration in the community, once investigators understand the nature of this opposition, they should attempt to find the most appropriate public education techniques to decrease it. He cites four critical areas related to the community integration of ex-patients.

First, mental health professionals should be made aware of the impact of community opposition on the lives of the mentally ill. According to Baron, "Mental health professionals are only now willing to grapple with the reality that deinstitutionalization . . . has been neither a therapeutic nor a public relations success." Due to both inadequacies in patient care and community opposition, community placement does not necessarily lead to community integration. In order to improve patient care, more funding is needed which, according to Baron, can only be a byproduct of general public support. Further, the placement of community facilities is also related to public support. Baron states, "Without a broadening of public

support, we are condemned to seek out only those communities willing to accept certain categories of high-functioning clients on an ever-narrowing set of restrictive conditions, leading inevitably to a circumstance in which—once again—the chronically disabled have little hope of rejoining society."

The second critical area is implementing public education efforts that focus upon public acceptance of the chronic mental patient in the community. Baron feels that the few public campaigns that have addressed community opposition have promised more than could be delivered, given an ex-patient population with many individuals who have behavioral abnormalities. Baron suggests that the cooperation of both public education and attitude research specialists is needed to improve the prospects for community integration. Public educators need to understand the "attitudes, concerns and prejudices of their target audiences."

The third area of importance is delineating public attitudes toward mental illness. For example, "It may be useful . . . to distinguish between the general images evoked by the term 'mental illness,' and the specific impact community residents feel the deinstitutionalized mentally ill will actually have on their lives." Baron lists five separate factors that interact to shape public responses: 1) opinions about the origins of mental illness; 2) a general social intolerance of deviant behavior; 3) personal or familial experiences as mental health consumers; 4) prior contact in community settings with the mentally ill; and 5) exposure to media images. These factors are central to public education efforts. Baron states, "If the attitudes and opinions that serve as major barriers to community acceptance can be defined, they ought to provide central thematic material for educational programming; if the informants [or factors] that are most powerful in shaping current public concerns can be determined, then they ought as well to serve as the most effective intervention tools in reshaping public responses."

Several methodological issues present themselves to those studying public attitudes. The definition of terms is one such problem. Baron asks several questions: Should a community be defined in geographic terms, in ethnic terms, or in socioeconomic terms? How should the terms "mental illness" and "mental health facility" be defined? How can residential, racial, and social integration of the mentally ill in the commu-

nity be measured precisely and adequately? Another methodological problem, according to Baron, concerns a bias in most of the professional literature toward the study of factors which inhibit rather than promote community integration. What defines an accepting community? What factors encourage employer receptivity to mental health consumers? Baron mentions another methodological problem inherent in almost any survey of attitudes: the tendency of respondents to give the socially desirable response and not admit publicly hostile feelings toward having the mentally ill in their community.

The fourth major area of concern, according to Baron, is assessing the impact of various public education techniques. Public education researchers must collaborate with attitude researchers to understand the relationship between attitudes and behavior. Whether one believes that attitudes cause behavior or that behavior causes attitudes will influence the public education strategy one chooses. Baron defines two such strategies: "collaborative" and "structural." A collaborative approach involves the community in the deinstitutionalization process and is essentially democratic. Communities are asked "to openly examine prevailing attitudes" in the hope that enlightened behavior will follow. By contrast, the structural approach "dictates the utilization of social, legal, or media levers to promote community integration despite public sentiment, in which the penalties for refusing to change behaviors are so punitive or the social pressures to restrain rejecting behaviors are so intense" that the mentally ill are at least guaranteed a chance.

Choosing between collaborative and structural strategies often forces a reexamination of personal values. As Baron points out, "Those who establish a primary allegiance to the mentally ill client are inclined not only to view community care as a therapeutic prerequisite but also to consider community opposition as an unjust infringement upon the civil liberties of the client population. They thus prefer structural solutions." Others, however, "find they have a much stronger allegiance to the ideals of 'community control' . . . and faith in the benefits of the democratic process. . . . They are more willing to accept the delays . . . of a truly collaborative strategy in order to gain the long-term benefits of a genuinely accepting community." Although a majority of those who operate residential

facilities prefer collaborative approaches, growing numbers of operators cannot accept the delays inherent in a collaborative approach. Perhaps a combination of strategies would be most effective in helping to integrate the ex-patient in the community. According to Baron, "The final challenge is to provide public educators with an assessment of the effectiveness of their programs, whatever strategies they select." Ideally, public education programs should strive to improve public acceptance of the mentally ill while assessing the efficacy of the public education programs themselves.

RESEARCH RECOMMENDATIONS

Very little research exists on the kinds of information needed to help the general public understand the various types of mental illness. Existing programs have often concealed rather than elucidated the facts. Often public education programs have failed to communicate that most mental illnesses are transitory.

- Various approaches to public education need to be designed. Such efforts need to address the concerns of the general public including dangerousness, deviance, and unpredictability.
- Research is needed on how to conduct public education programs with gatekeepers such as employers, legislators, police, and landlords.

ECONOMIC FACTORS AS THEY RELATE TO MENTAL ILLNESS

How Rehabilitation Programs Deal with Stigma Toward the Mentally Ill

James S. Peters, II

James S. Peters describes how the State of Connecticut has expanded its rehabilitation efforts to include the mentally ill. As early as 1948, the Connecticut State Hospital started the first vocational rehabilitation program in a mental institution. Later, services were extended to patients in every neuropsychiatric institution in Connecticut. To determine the effect of a vocational workshop on patients, Peters conducted a research study measuring the "socio-egocentrism" (attitudes toward self

and others) of vocational workshop patients. He found that workshop patients had more positive self-concepts than non-workshop patients. In Peter's view, if deinstitutionalization is to be achieved, the role of vocational rehabilitation programs needs to be clearly delineated, and vocational programs need to be individualized and should include job placement and family counseling. A "Job Worksite" program can act as "a bridge that spans the protected environment of the vocational workshop and the real world of everyday work." Viable employment is essential for recovery of ex-patients, according to Peters.

The work environment may be the most important source of social support next to the family for many people. Many who have been institutionalized for long periods of time have lost contact with family members. For such people, the employment situation may provide the only source of community support. However, it is estimated that only between 10 and 30 percent of former patients are employed at any single point in time. As Steadman has pointed out, released mental patients are younger now than they were in previous decades. With limited work experience, their employability is limited. The lack of work experience, together with the negative attitudes and hiring practices of employers, means that for most former patients unemployment is a familiar fact of life. Up-to-date research is needed to answer questions concerning the kinds of jobs former patients can fill, which incentives induce employers to hire them, and how those soon-to-be discharged can best be prepared for the job situation. Research is needed on the kinds of social support required to keep people on the job once they are employed.

Stigma and Astigmatism and Mental Health Fiscal Issues

Donald W. Hammersley

Donald Hammersley looks at stigma and its effect on funding mental health care. He suggests that a stereotyped, negative view of mental illness might be a cause for inadequate funding for services. He states that one outcome of the public's negative attitude toward the mentally ill "is minimal expenditure of public funds for care, confinement, rehabilitation or treat-

ment," and the assumption that the family is responsible, as a rule, for its ill.

The family of the mentally ill person may feel that society can offer no financial support or assistance. However, the family may also fail to utilize the assistance that is available for various reasons. For example, "Some families may belligerently deny responsibility altogether, while others may realistically point out that their finite financial resources have competing priorities." Thus, limitation of financial resources is often a factor in the failure of families to seek mental health services.

Other fiscal issues related to negative attitudes toward the mentally ill concern the legislative process and its effect on mental health program funds. As Hammersley points out, "Inflation, recession, energy, unemployment, and instability of foreign affairs are . . . of overriding public concern compared . . . to funding for the mentally ill." According to Hammersley, funding would seem to depend on such favorable factors as "a solid front of advocacy, charismatic leadership, compelling data, favorable economy," and an "upswing of humanistic concern in Congress." In addition to these factors, the nature of comprehensive mental health services requires a "multisource funding matrix." To overcome resistence to legislation aimed at funding mental health programs, Hammersley suggests having well-organized and relevant data on hand to combat possible stigma.

Another issue related to funding is a family's reluctance to use third-party payment benefits for mental health care. Hammersley suggests that some families' reluctance to use insurance benefits might result from a fear of stigmatization. Fear of loss of privacy and confidentiality can also be a major concern to both the patient and the provider in the therapy setting. Hammersley suggests, then, that the fear of the negative attributions attached to mental illness should be kept in mind in assessing reasons for the underutilization of mental health insurance benefits. It is possible that "Some patients may pay cash (if they can afford to) for services in order to enhance privacy."

Negative attitudes toward mental illness can also affect service provided. If psychiatrists and other providers were to adhere to the medical model of illness and perceive mental

illness as a disease like any other, negative attitudes toward mental illness might be reduced, and insurance coverage might be more easily obtained. On the other hand, other mental health professionals think that using the medical model increases the chance for negative attributions toward the mentally ill. To avoid this problem, it has been suggested that nonmedical therapists treat mental health problems. A concern for privacy and confidentiality of patient information also affects the provider. As Hammersley states, "Having to get informed consent from the patient to disclose information to the fiscal intermediary is seen as at the least a wasteful intrusion into therapy and at worst a significant constraint to therapy." Giving an inaccurate diagnosis can be one solution for providers faced with the dilemma of possibly stigmatizing a client.

As Hammersley points out, concern about negative attitudes towards those treated for mental health problems can affect the diagnostic information provided to third-party payers. Two studies reported by Steven S. Sharfstein and colleagues indicate that information submitted on claims forms to insurance companies tends to minimize the severity of the diagnosis. Blue Cross and Blue Shield insurance-claims data were compared with an anonymous survey conducted by the Washington Psychiatric Society. The authors found a remarkable similarity between the age groupings in the two studies but striking differences in diagnostic categories. While more than 84 percent of the Blue Cross/Blue Shield patients received a diagnosis of neurosis, only about 28 percent received this diagnosis in the Washington Psychiatric Society survey. It was concluded that concerns about patients' confidentiality of a sensitive clinical nature led to diagnoses of a less "severe" nature.

The fiscal intermediary has a different perspective than the client or provider. Hammersley says, "Physicians often do not understand the legitimate needs of the fiscal intermediary" and do not create collaborative relationships that would enhance patient care. Third-party payers can be just as interested in good patient care as the physician or other providers. Their resistance to extending a mental health benefit may stem from either negative attitudes toward mental illness or an awareness that insurance benefits are being improperly utilized.

Hammersley details the reasons for the lack of funding for State mental hospitals. In his view, when deinstitutionalization

began, it was thought that "the service dollar could follow the deinstitutionalized patient into the community from the State hospital." However, instead, "Lack of community dollars fostered neglect of the chronic mental patient and high readmission rates were grim testimony to this." Hammersley suggests that the reasons for the poor services provided in State hospitals should be studied.

DISCUSSION

The discussion related to Hammersley's presentation centered on how public attitudes toward mental illness interact with economic issues to create a number of professional problems which, in turn, affect the kinds of treatment provided. Psychiatry is not one of the more prestigious or more remunerative specialties within the medical profession. Currently, psychiatry training programs are having difficulty recruiting residents. There is now and is likely to be in the future a shortage of qualified psychiatrists to provide care. This shortage is most acute in public institutions and in rural and low-income areas.

The Community Mental Health Centers do not, for the most part, provide services for those most in need. Therapists at these facilities are more apt to provide services for those in crisis situations than for the deinstitutionalized patient or the chronically mentally ill. Therapists often seem to share the attitudes of the general public and are not eager to deal with the chronically mentally ill.

As more mental health care reimbursement is assumed by third parties, it is reasonable for insurance companies to want to know which mental patients can be rehabilitated rapidly, which patients will require long-term care, how long it will take, and how much it will cost to provide services to people with different kinds of mental illnesses.

RESEARCH RECOMMENDATIONS

- New research efforts must be directed toward providing more definitive answers to key questions in the field: What are the specific concerns of contemporary employers with regard to hiring those who have been treated for mental illness? How do employers' attitudes vary across firms of

different sizes and in different industries? What impact do such attitudes have on the hiring practices of employers?

- Research is needed to assess the kinds of economic or other incentives likely to encourage employers to hire former mental patients and to determine why Sections 503 and 504 of the Vocational Rehabilitation Act of 1973 have left the employment situation of former patients virtually unchanged.
- Studies are needed to assess the types of job situations and employee factors associated with successful job placement.
- Additional research should explore the reasons for the high rate of job loss among the mentally ill in the period soon after placement. Such studies should determine the most effective interventions (e.g., follow-up counseling, employer services, information campaigns for other employees, and family counseling) to help employers retain those they have hired.

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